

Sound Decisions: An Undergraduate Bioethics Journal

Volume 2 | Issue 1

Article 1

2016-12-15

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Recommended Citation

Nevins, McKinley (2016) "Advocation for the Universal Legalization of Physician-Assisted Suicide as a Last Resort Measure," *Sound Decisions: An Undergraduate Bioethics Journal*: Vol. 2 : Iss. 1 , Article 1.
Available at: <http://soundideas.pugetsound.edu/sounddecisions/vol2/iss1/1>

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Advocation for the Universal Legalization of Physician-Assisted Suicide as a Last Resort Measure

McKinley Nevins

ABSTRACT: Considerations of physician-assisted suicide are pressing, emotionally charged, and urgently needed. Current safeguards that exist to protect the patients from coercion and abuses of power are crucial, but incomplete. Additional safeguards must be implemented to protect the role of physicians in cases of PAS as well. Also, improved palliative care measures should be advocated for and considered as the best option in cases of individuals suffering horrendously in the last month of a terminal illness. The universal legalization of physician-assisted suicide in all 50 states should be advocated for, so that once all palliative care measures available have been exhaustively explored, terminally-ill and suffering individuals have the ability to end their lives with dignity and on their own terms.

With the passage of Oregon's *Death with Dignity Act* in 1994, physician-assisted suicide (PAS) was made legal under strict conditions (Vaughn 2013). Since this action, issues of physician-aided dying have appeared regularly in courtrooms and the popular, and frequent polls show a major rift in public opinion (Des Chenes and Merino 2012; Lipka 2014), all speaking to the shift of the discussion surrounding PAS from largely theoretical and academic to that of an unavoidable and pressing social issue. Modern advances in life-sustaining medical technologies, as well as palliative care, have enabled physicians to keep terminally-ill patients alive longer and increasingly improve their quality of life more than ever before, but in some cases the best care still is not good enough. For terminally-ill patients who are suffering unbearably in their final months of life, a liberating solution is available, but only if they are residents of one of a very small number of states that have legalized physician-assisted suicide (PAS). The autonomous right that all persons possess to determine how they live their lives should not be suspended during the time that their life is coming to an end. The universal legalization of physician-assisted suicide in all 50 states should be advocated for to allow individuals suffering from

incurable, unendurable conditions the equal opportunity to end their lives on their own terms, but the practice must be highly regulated in regards to both the patient and the physician; improvements in palliative care should be strongly promoted and fully explored before physician-assisted suicide is considered in individual cases. I will support this argument with considerations of the four bioethical principles – autonomy, beneficence, utility and justice, as well as with further discussion of egalitarian justice and rule-utilitarianism.

Pertinent Definitions

In order to carry out an effective discussion of the issues surrounding physician-assisted suicide, precise definitions of the relevant terminology must be used. For my purposes I will now clarify my definitions of active, passive, voluntary and non-voluntary euthanasia, and physician-assisted suicide (PAS). Thomasma and Graber (1990) state that,

“Euthanasia itself can be distinguished from murder on the basis of motive. Murder would be killing someone for reasons other than kindness. The difference between active and passive forms of euthanasia cannot be sustained on the basis of motive alone... Rather, the difference lies in the nature of the act itself. Active euthanasia brings about a kind death through direct intervention. The act performed directly kills the patient. Passive euthanasia, by contrast, is the withholding or withdrawing of life-prolonging or life-sustaining technologies... withdrawing such treatment means that the dying process continues unabated.”

The distinction between voluntary and non-voluntary euthanasia relies on the presence or absence of consent given by the patient – voluntary consent is given by patients that are deemed mentally and physically competent; non-voluntary euthanasia is performed on patients who are incapable of giving consent, such as very small children and incapacitated adults (Vaughn 2013).

Finally, and most important for our discussion, physician-assisted suicide is a situation in which a patient, under strict conditions, requests a prescription for a lethal drug from a physician, and it is the patient, not the physician, who carries out the act of taking the drug to cause death (Vaughn 2013).

A Crucial Distinction

Passive voluntary and involuntary euthanasia are widely accepted, as it has been repeatedly decided judicially that competent patients have the right to refuse treatment, and the surrogate decision makers of incompetent patients have the right to decide to withhold or withdraw life sustaining measures – if they believe that action would align with the patient's wishes (Vaughn 2013). The moral and ethical issues here-in lie with active voluntary euthanasia and physician-assisted suicide – it is frequently argued that there is no significant difference between the two (Vaughn 2013; Weir 1997); I argue that a difference does exist, and it is crucial to the further legalization of PAS. In physician-assisted suicide, the physician provides the means of suicide, but the patient is the one who makes the final decision of whether or not to take the prescribed drug (Thomasma and Graber 1990). In a case of active euthanasia, the physician directly carries out the action that is responsible for the death of the patient. The patient's autonomous decision in PAS acts as a buffer between the role of the physician and the (possible) death of the patient.

The principle of autonomy operates on the idea that an autonomous individual should be allowed to carry out their own self-determination, due to their intrinsic worth and ability to make rational and moral decisions (Vaughn 2013). Present safeguards on PAS operate, in part, to ensure the rationality of the patient making the request for the prescription suicide drug. If they are confirmed to be in a rational mental state, including not suffering from depression, and all

other requirements of the PAS safeguards are met (which are discussed further below), the patient's request should not be denied, because that would act to restrain the person's autonomy. In the majority of cases, patients requesting physician-assisted suicide cite non-physical fears of, "losing control, being a burden, loss of dignity, and being dependent on others for personal care" as their primary reasons for seeking PAS, not the mere abatement of their physical pain (Weir 1997).

The Inadequacy of Current Safeguards

Legislatively mandated safeguards currently in effect in states such as Oregon, with its *Death with Dignity Act* (Oregon Health Authority, n.d.), are crucial but largely one-sided. In simple terms, these guidelines require that Oregon residents requesting a lethal prescription must be: (1) over the age of 18, (2) "capable", that is, "able to make and communicate healthcare decisions", (3) have a terminal illness (4) that gives them less than 6 months to live, and (5) must make three requests for the drugs – one written and two verbal, (6) with at least 15 days in between, (7) and in the presence of two witnesses (Hedberg and Tolle 2002). These strict requirements are implemented to ensure that the patient is of sound mind, sure of their decision, and free from any form of coercion to end their life. Safeguards to protect the physician from coercion are necessary as well, but are largely absent.

Considerations made with respect to the physician, aside from the primary ones dealing with the morality of PAS itself and the physician's role in the process (Back et al. 1996; Vanderpool 1997; Callahan 1997), typically consist of survey studies conducted on various populations of physicians from varied states and specialties. General opinions of PAS held by physicians are mixed – in a survey conducted in 1994, 43% of physician respondents said that they supported legalization of PAS, and 54% said they would participate in the practice if it was

legal (Gianelli 1994). In a national survey conducted four years later, 11% of physicians questioned said they, “would be willing to hasten a patient’s death by prescribing medication: under current legal restrictions in their state, and 36% said they would do so if the practice was legal (Meier et al. 1998). These two early surveys demonstrate the high variability in the opinions held by physicians on the issue of PAS. To better take this diversity of opinions into account, more extensive regulations must be implemented, along with the preexisting safeguards for the patients, in order to simultaneously protect the physicians involved in a PAS case from coercion as well.

I argue that terminally-ill patients should have equal access to physician-assisted suicide in any state, but that in no way gives them the universal right to the process itself – if no physician can be found that is willing to carry out their role in the process, no one can be mandated to do it. Boards of physicians should be created that solely consider requests and carry out cases of PAS. Eligible patients should not be denied PAS if their primary care physician does not consider the practice morally licit, instead, any physician from the board that is familiar with the case and considers PAS morally and ethically sound could take over the case and grant the patient’s final wishes. This frees the primary care physician from any coercion to carry out PAS that may stem from the likely close relationship that they share with their patient, while at the same time does not ignore the patient’s autonomous right to make the request.

An added benefit of the board system would be an additional level of oversight to ensure that PAS is truly the best and final option for any patient seeking it, and to aid in the prevention of abuses of power – one of the largest criticisms of PAS, along with its effect on the doctor-patient relationship. Empirical evidence exists to contradict both of these concerns: analysis of the prevalence of PAS in vulnerable groups in the Netherlands, such as the elderly, women,

disabled people, and racial and ethnic minorities, showed no significant difference in the use of PAS between these groups and every other social category of patient (Vaughn 2013); surveys of patient opinions on their physicians' involvement in PAS found that 91% of respondents considered a physician that assisted with suicide to be a "caring person", and 90.5% of respondents said that they would find a physician that participated in PAS to be just as trustworthy as one that did not (Weir 1997).

Critics cite such concerns as part of an overarching fear that physician-assisted suicide will change the way that physicians are viewed in society, will ruin the trust that the doctor-patient relationship is founded on, and the more widespread legalization of PAS will lead to the implementation of active voluntary and, eventually, involuntary euthanasia (Vaughn 2013). A survey of the major world religions found similar concerns articulated (by those faiths that had formulated an official statement on the issue) (Larue 1985). These concerns form a slippery-slope argument, and the likelihood of them occurring is extremely slim. The empirical evidence demonstrates that the limited legalization of PAS thus-far has not significantly negatively affected the standing or trustworthiness of physicians in society, and the patient safeguards already in existence, combined with my proposed physician safeguards, would serve to prevent coercion, minority targeting, or other abusive practices. The difficulty surrounding the legalization of PAS in states thus far also serves to suggest that the legalization of much more radical forms of voluntary and involuntary euthanasia would likely never occur in this country.

Universal Accessibility and Regulated Implementation

The current system of the decriminalization of the physician-assisted suicide completely neglects overarching considerations of justice. Under the theory of egalitarian justice, everyone in society should receive an equal share, or have equal access, to all social benefits (Vaughn

2013). The restriction of legalized PAS to a minute fraction of the country is an unfair distribution of the social benefits that can be gained from physician-assisted suicide by the patients that meet all of the requirements. The ability of a patient to discuss and seek out the option of PAS in their last weeks of life, and in their own state of residence, is a capability that every individual should have. As discussed briefly above, access to PAS and a right to PAS are two very different things. I am advocating for universal access to PAS through its legalization in all 50 states, but I do not believe that PAS should be a positive right of citizens/patients. A positive right is one held by an individual that necessitates that a certain action be carried out for that individual; in contrast, a negative right necessitates inaction in some situation (Weir 1992). If PAS were considered to be a positive right, the extensive safeguards of the practice would lose their efficacy, which would then open it up to abuses.

The Rules of PAS

Rule-utilitarianism focuses on rules governing categories of actions, and states that, “a right action is one that conforms to a rule that, if followed consistently, would create for everyone involved the most beneficial balance of good over bad” (Vaughn 2013). When applied to my argument for the universal legalization of physician-assisted suicide under certain conditions, these conditions would constitute the “rules”: both patients and physicians must be safeguarded from coercion and all palliative care measures should be sought after before PAS is even considered as a possible option to ease the suffering of the patient.

The utility, or the balance of good over bad, of PAS can be judged on two scales – that of the society, and that of the individual. From a societal standpoint, universal legalization of PAS would facilitate the provision of the most good for the largest number of people by providing them with a strictly regulated means of ending their lives if they were terminally-ill and suffering

unbearably. The benefits gained would outweigh any burdens that could arise from the effects of the implementation of PAS on the physicians' standing in society and the devaluation of human life through possible abuses of the practice, because the likelihood of either event occurring is not supported by the empirical evidence / allowed for in the design of the safeguards I support and propose further.

On an individual basis, the ending of the life and abatement of suffering of the patient was the goal of that individual from the beginning of their pursuit of PAS, and would therefore be considered by them to be a benefit. For the families and caregivers of these individuals, the removal of their loved one's / patient's suffering would likely be viewed as a benefit, and would be valued over the burdens of the despair and loss felt after their death. If the patient did not choose to use the prescription suicide drug, they could still receive some benefits from the process. Multiple first-hand accounts from patients that sought out PAS, whether they took the suicide drug in the end or not, reported great feelings of relief and peace after receiving their prescription ("My right to die with dignity at 29" 2014); such feelings allow the patient to focus on other things, such as enjoying the company of their loved ones, instead of their constant fears and anxieties related to the dying process (Weir 1997).

Following the basis of rule-utilitarianism as it relates to PAS, if the rules pertaining to the safeguard that already exist for the patient, and that I advocate for for the physician, are honored and maintained, and all options of palliative care are pursued prior to considerations of PAS, then the most good should be obtained for the largest number of people. Universal legalization of PAS needs to be carried out to make this "good" equally accessible to everyone.

The Palliative Care Component

Aspects of the improved palliative care that I am advocating for need to be addressed. I argue that PAS should be made available to everyone, but I consider physician-assisted suicide to be a very last resort in a long string of treatment options that can be considered. PAS should only be used when every other option to aid in the abatement of the suffering of the patient have been considered and found to be ineffective. As per the obligation of the physician in society, one aspect of which is considered to be “to control the suffering and pain of [the dying person]” (Thomasma and Graber 1990), administration of individualized and attentive palliative care should be of the utmost priority for physicians of patients with terminal illnesses. It is recognized though that the end of life care system in our country is quite lacking (Goldsmith et al. 2008), but palliative care is still recognized by the vast majority of scholars on the issue of PAS as the best alternative to its use whenever possible (Sachs et al. 1995).

Principalism and PAS

Of the four principles of bioethics outlined by Beauchamp and Childress (1983) – autonomy, beneficence, justice, and utility – beneficence has been left unaddressed thus far. The principle of beneficence says that, “we should do good to others and avoid doing them harm,” or more precisely, “we should not cause unnecessary injury or harm to those in our care” (Vaughn 2013). In consideration of physician-assisted suicide, the central judgment of the beneficence of the action rides on how the term “harm” is defined and interpreted in this context. Critics of PAS and active euthanasia argue that the death of the patient that results indirectly from the action of the physician in PAS, and directly from the action in active euthanasia, is the ultimate harm that can be inflicted on someone, and therefore PAS and active euthanasia violate the principle of beneficence (Vaughn 2013). I argue that forcing someone to continue to suffer under unbearable physical and emotional pain causes more harm than their death, which is viewed by the patient as

an escape from their agony. The autonomous right of the patient to decide to take / not take the suicide drug, and the safeguards put in place to protect the patient from coercion and abuses of power, all help to ensure that the patient is seeking PAS solely to achieve their death for this purpose.

Conclusion

Considerations of multiple moral theories support my argument that the legalization of physician-assisted suicide should be advocated for in all 50 states. It is the autonomous right of patients to request PAS where it is currently legal (if they meet the requirements), but the small fraction of US states that have legalized PAS conflict with the theory of egalitarian justice – that it is the right of all individuals to have equal access to the option of PAS, but not necessarily its use. In fact, strict safeguards, which act as the “rules” in a rule-utilitarian framework, are meant to ensure that neither the patient nor the physician is coerced into any aspect of PAS, that the system is not abused, and that, in general, it only be used as a last resort after all possible palliative care measures have been explored. If these “rules” are followed, a positive ratio of benefits to burdens should be achieved by the legalization of PAS.

Considerations of the issue of physician-assisted suicide are pressing, emotionally charged, and urgently needed. I believe that my argument in support of the existing safeguards, the implementation of boards of physicians to further protect them from coercion and abuses of power, and the exploration and application of all palliative care measures possible combine to support the universal legalization of PAS. Physician-assisted suicide should only be carried out when all other options to ease the suffering of a terminally-ill patient have failed, but it is morally right and morally necessary to make the right to consider PAS accessible to all US citizens in those cases.

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